Date_____

Behavioral Health Initial Assessment Note

This information is protected by the **Privacy Act** of 1974 (5USC 552a)
Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United State Code and Execution Order 9397.

Please read and answer the following:

Biographical Information:

Name: _____AGE: _____ DOB: ___ /___ / ___ GENDER: M / F Rank: _____
Last First MI Day Mo Yr

Military Status: ? AD ? FM ? Retired ? other _____ Sponsor's SSN: _____

Branch of Service: ? A ? AF ? N ? CG ? MC ? other: _____

Local Address: _____Ethnic Background:_____

Home Phone: (___) _____ Wk Phone: (___) _____ Beeper #: (___) _____

Unit/Duty Section: _____Unit Commander:_____

1SG: _____ Platoon Ldr/Section OIC: _____ Platoon SGT/NCOIC: _____

Unit Phone: _____

Did someone refer or suggest you come to our clinic? If so, Please give the person's title or relationship to you.

What difficulties, symptoms, problems or complaints are you having that caused you to come to this clinic TODAY?

Are you having problems or have you had recent changes in any of these areas? If so, please describe.

Sleeping Y/N_____

Energy Y/N_____

Appetite Y/N_____

Weight Y/N_____

Concentration Y/N:_____

Self-esteem Y/N:_____

Sex drive Y/N: _____

Sexual functioning Y/N_____

What sort of activities have you enjoyed lately?_____

	YES	**NO**
Are you currently thinking about hurting yourself?		
Are you Currently thinking about hurting someone else?		
Do you have plans how you would do it?		
Currently thinking about going AWOL?		
How would you assess yourself as being at risk on the scale of 0 (no risk) to 10 (imminent danger of hurting self/others)?		

Please explain your situation, what you want to change, and how you would like us to help you.

Please describe your living situation (people in your household).

Is there anything else you would like us to know?

Past Mental Health Treatment:

In the past were you ever treated or hospitalized by a psychiatrist, psychologist or other mental health professional? Y / N
If so, please describe:

Family History:

Where were you born?_____ Where did you grow up?_____
City State City State

Have your parents ever been: ? Separated ? Divorced ? Remarried ? Always lived together

If separated, divorced, or remarried , how old were you when this happened? _____

You were raised by: ? Mother ? Father ? Parents ? Grandparents ? Foster parents ? Other_____

List age of:	Brothers	Sisters	Stepbrothers	Stepsisters
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Describe any serious medical illnesses in your family and who had them:

_____

_____

Has any member of your family received any treatment or been hospitalized for any nervous, mental, emotional, psychiatric or psychological problems? Yes / No If yes, please describe: _____

_____

_____

Has any member of your family received counseling, treatment or hospitalization for alcohol and / or drug-related problems? Yes / No. If yes, please describe:_____

_____

_____

Are any members of your immediate family (i.e. brother, sister, father, mother) deceased (not living)? Yes / No.

If yes, what did he/she die from?_____

_____

_____

Father's age: _____Occupation: _____Mother's age: _____Occupation: _____

Please briefly describe your relationship with your family? In your childhood and today. _____

_____

_____

Were you ever the victim of emotional, physical, or sexual abuse?_____

Has religion played an important role in your life?_____ What faith do you practice? _____

Education

Highest level of education? ____ GED? Y / N_____College or vocational school degree? _____In what field? _____

Legal History

Describe any legal problems, arrests or jail experience which you may have had. _____

_____

_____

Marital History

What is your present marital status? ? M ? S ? D ? W ? Sep ? Other _____

How long have you been married? _____ Number of marriages for self? _____Spouse?_____

Name and age of Spouse: _____

Does your present spouse live with you? Yes / No_____

If not, where does spouse reside?_____

List ages of children: Sons: ___Daughters: _____ Stepsons: _____Stepdaughters: _____ NONE _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you having marital problems? Yes / No.

If yes, please describe:_____

Medical History

Are you presently under the care of a physician for any medical illness or condition? Yes / No

If yes, please describe:_____

_____

_____

Have you ever been hospitalized or undergone surgery?_____

_____

_____

Are you taking any over the counter or prescription medications? Yes / No.

If yes, please list: _____

_____

_____

Have you taken medication for psychiatric difficulties such as depression or anxiety in the past or currently? (list dose, why discontinued, side effects, effectiveness including over time): _____

_____

_____

Please describe any allergic reactions/side effects to medications you have taken. _____

_____

_____

Do you have any physical symptoms or aches and pains? If so, please describe. _____

_____

_____

Have you ever been knocked unconscious, had a seizure, fit or epilepsy, or found yourself in a strange place without knowing how you got there? Yes / No

If so, please describe _____

_____

_____

Substance Use History:

How many glasses of wine, beers, mixed or straight drinks do you have on weeknights?_____

Weekends? _____

Have you ever experienced as a result of drinking alcohol: (Please circle)

Problems at work or with your family DWI's Blackouts Withdrawal symptoms

Do you use or have you used cocaine (crack/snow), marijuana, LSD (acid), amphetamines (speed, uppers, crystal meth., ice), heroin, barbiturates (downers), glue, PCP, Quaaludes or other drugs? If so, please explain what, when and how often? _____

_____

_____

Have you ever attempted to cut back on alcohol? Yes / No

Have you ever been annoyed by comments made about your drinking? Yes / No

Have you ever felt guilty about drinking? Yes / No

Have you ever had an eye-opener first thing in the morning to steady your nerves? Yes / No

Do you smoke cigarettes or use other tobacco products? Yes / No

If yes, please describe how much and how long have you done so: _____

Do you use any caffeinated beverages such as coffee, tea, or cola beverages? Yes / No

If yes, please describe how much and what types: _____

Military History:

Total time in service: _____ Last PCS date: _____ DEROS:_____ ETS date: _____

MOS: _____ Description: _____

Did you get the MOS you wanted? Yes / No If not, please explain: _____

Are You **PRP**? Yes / No **Flight Status**: Yes / No

How do you feel about your present duty assignment?_____

Any difficulties with people in your unit? Yes / No

If yes, please describe: _____

Any difficulties in doing your job? Yes / No

If yes , please explain: _____

List any Article 15's (AR) /courts martial (CM) below:

	Date	Offense	Punishment
AR15's	_____	_____	_____
CM	_____	_____	_____

For Women Only:

When was your last menstrual period?_____ Are your periods regular? Yes / No

Do you have painful periods? Yes / No

Are you tense, anxious or depressed before your periods? _____

Number of pregnancies? _____ Number of children? _____